

Unearthing the Buried City

The Janet Translation Project

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This document is part of *Unearthing the Buried City: The Janet Translation Project*, a series of AI-assisted English translations of Pierre Janet's works.

In his seminal 1970 book: *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry*, Henri Ellenberger wrote:

Thus, Janet's work can be compared to a vast city buried beneath ashes, like Pompeii. The fate of any buried city is uncertain. It may remain buried forever. It may remain concealed while being plundered by marauders. But it may also perhaps be unearthed some day and brought back to life (p. 409).

This project takes Ellenberger's metaphor seriously — and literally. The goal of this work is to unearth the buried city of Janet's writings and make them accessible to the English-speaking world, where much of his legacy remains obscured or misunderstood.

Pierre Janet was a pioneer of dynamic psychology, psychopathology, hypnosis, and dissociation. His influence on Freud, Jung, and the broader psychotherapeutic tradition is profound, yet the bulk of his original writings remain untranslated or scattered in partial form. These AI-assisted translations aim to fill that gap — provisionally — by making Janet's works readable and searchable in English for the first time.

This is not an academic translation, nor does it claim to replace one. It is a faithful, literal rendering produced with the aid of AI language tools such as Chat GPT and DeepL and lightly edited for clarity. Its purpose is preservation, accessibility, and revival. By bringing these texts to light, I hope to:

- Preserve Janet's contributions in a readable English form
- Spark renewed interest among scholars, clinicians, and students
- Inspire human translators to produce definitive, academically rigorous editions

Story of a Fixed Idea¹

Pierre Janet

It is still very difficult today to determine in a general way the psychological laws that govern the diseases of the mind: hasty generalizations always lead to conceptions as narrow as they are absolute. In this field of study, as in others, one must know how to remain for a long time with observation and the description of particular facts; it is good to seek first to understand the patient before trying to explain the illness. This is why you will excuse us if, in our research on fixed ideas, we do not yet enter into the study nor into the bibliography of the question considered in a general manner, if we stop again at the analysis of a particular case. This will be an opportunity to verify the notions we have already expressed concerning another patient² and perhaps to point out a few new ones.

The person to whom we are devoting this study today is a forty-year-old woman whom we shall designate under the conventional name of Justine. We first met her three years ago, at the consultation of M. Séglas, who was kind enough to refer her to us. Without admitting her to a hospital, which was never necessary, we arranged for her to come see us regularly in the various departments where we conducted our medical studies. Thus we studied her first every eight days, then at more widely spaced intervals over three years. Her mental state, very serious at the beginning, gradually and fortunately improved, and for over a year now she has recovered, as much as this is possible. It seems to us that this improvement is now sufficiently stable for us to describe the current state of the patient and to consider the analysis of this person as for now fairly complete.

When Justine was brought by her husband to the Salpêtrière in October 1890, she presented herself in the following way. She is a tall and strong woman, with thick and very black hair, very dark brown eyes wide open and fixed; her features would not be unpleasant if they were not disturbed by grimaces and continuous tics; her face alternated between very pale, blotched with red spots; her hands were clammy and trembling, her gait uncertain. As soon as one examines this woman, she hides her face in her hands and exclaims in sobs: "Oh! It is horrible to live like this, I'm afraid, I'm afraid! — Of what? — I'm afraid of cholera." This phrase summarizes the whole observation: it is a disease obsessed with the most banal idea, the idea of an illness, the idea of cholera. Precisely because this idea is so simple and limited, it seemed useful to us to analyze it, to follow its evolution and, if possible, its disappearance. Although Justine's personal and hereditary antecedents are very interesting, we will not present them at the beginning of this work. Their study raises delicate questions that would distract us from our main subject, the analysis of a fixed idea. We will return to them later when we try to understand the nature and origin of this illness.

¹ Janet, Pierre. "Histoire d'une idée fixe," *Revue philosophique*, xxxvii (1894), I, pp. 121-168.

² *Étude sur un cas d'aboulie et d'idées fixes* (*Revue philosophique*, 1891, I, p. 258 and 382).

I. The Idea of Cholera

Without studying for the moment the various incidents that characterized our patient's life, we will briefly recall the facts that relate to the current fixed idea. Justine, who has always been extremely emotional, had since her youth been very frightened by the thought of death. This preoccupation with death was no doubt tied to the profession of her mother, Justine's mother. She was a nurse and often had to tend to and bury the dead; sometimes she even let her daughter help her with these painful tasks: Justine, at the age of six or seven, was very affected by the sight of two corpses of cholera victims. She returned home preoccupied and, although she said she felt nothing, she could not help in the following years from frequently thinking of these cholera victims. This thought was not continuous, but it recurred for periods of sadness and fatigue and remained still vague and imprecise; "it was only an idea," said the patient in a simple phrase which we will understand better in a moment. However, this young girl thought about death, dreamed already while fully awake; she felt a voice say to her within: "Give me your soul...", and she was surprised to respond aloud: "No, no." The idea was already taking on a pathological character.

The following year, a mild typhoid fever and perhaps strenuous and unhygienic work in a manufacturing plant caused a considerable worsening of her morbid preoccupations. Several times a day, Justine would turn pale, have cold sweats and tremors that could not be explained and that were due to an increasingly strong fear of cholera. These symptoms worsened over time and at the age of twenty-three we begin to see violent attacks of nerves appear which we will soon learn to assess in nature. One hoped, following the popular prejudice, that all these nervous accidents would be resolved by marriage: at twenty-eight, Justine married an excellent worker who showed himself full of affection and kindness for her and whom she loved very much. The marriage diminished the painful ideas only temporarily. Justine again experienced a series of fixed ideas during all the appearances of pregnancy. It was finally after her childbirth, and the death of her child, that the hallucinations began to appear. It was first a fleeting vision of a sick person whom she believed she recognized and who reminded her of her previous anxieties. But it was not just a minor and passing incident. The idea of cholera quickly reemerged, gradually took over all of her thoughts, and became more and more pressing in the form of a fear of death. We recently saw a new attack during which things deteriorated so severely that the husband resolved to consider Justine as insane and brought her to the Salpêtrière.

The patient no doubt presents very varied psychological disturbances; she is constantly in her room, does no work, and spends her life moaning or crying, speaks of nothing, understands little or nothing of what is said to her, etc., etc. But all these disturbances are difficult to assess; we will study them later once we have understood the principal phenomenon which certainly dominates all the others, the idea of cholera.

As soon as we question this person on this delicate subject, she becomes agitated, blushes and turns pale, begins to cry and only responds with a few words: "I'm so afraid... and for a long time;... I don't know why,... I don't know

what's making me afraid..." She cannot explain herself better, because she immediately seems to lose consciousness. All her limbs tremble, her teeth chatter and clench, her arms make defensive movements and her body jerks backward. After a few contortions, Justine begins to utter frightful screams, she keeps her eyes open, fixed as if looking at something, her mouth becomes foamy with a trickle of water running down her lips. From time to time, she makes out among her cries some intelligible words: "The cholera, it's taking me, help!" She has cramps and contractures in her legs, asphyxia, becomes bluish and vomits either her food or simply a liquid; eventually she arrives at losing control of her bowels. This scene goes on and is repeated a few times over several hours. Then the patient returns to a sort of consciousness; although she retains some contractures in her legs, she is relieved; she tidies the disorder of her clothing, and vaguely remembers from the traces that she has vomited, but has no precise memory. She remains reasonably calm for a few hours, but at the slightest allusion that recalls the idea of cholera, it all begins again.

How should we understand this whole scene? It is a hysterical attack. No doubt, this is the common name that easily designates a vast number of phenomena scarcely similar to these; but can we not specify more precisely the nature of this attack? When one examines the patient during her convulsions and her cries of terror, one is inclined to believe that she is conscious of nothing; one could shout in her ears without her responding, prick her or burn her without her reacting. It is, as it were, an illusion, conscious phenomena are not abolished; but the mind of patients absorbed by an overwhelming idea is no longer capable of perceiving them or retaining memory of them. It suffices, however, to provoke her intelligible manifestations, to determine phenomena related to what the patient perceives at that moment, to thereby enter into her dream. At the moment Justine cries: "The cholera, it's going to take me...", I respond: "Yes, it's holding your right leg," and the voice that speaks so violently grabs her right leg. In this way, one manages, with a little patience, to provoke responses and even questions from the patient herself: "Where is the cholera now?" — "There, you see it, black, like a blue heap, like that, it stinks!" When one has reached this point, one can slowly direct the mind toward other subjects and cause her to speak of other things. It is true that the conversation will be frequently interrupted by convulsions and cries of terror, but it will soon become more and more complete. At the end of the attack, Justine remembers no more of the interspersed conversation than of the delirium itself. These are well-known phenomena under the name of somnambulism, which will allow us to enter more deeply into the understanding of the attack itself. In the first experiments, we were obliged to provoke the attack before inducing this somnambulistic state; later, it became possible to almost completely eliminate the initial convulsions and to provoke the somnambulism more directly.

This procedure, which consists in transforming the hysterical attack into somnambulism, presents great theoretical interest; it is also practically useful. Among the many examples we have already reported, we can add a new one. Gu., who shows various symptoms of hysteria, has violent attacks that occur apparently without cause; moreover, she has a peculiar horror of the color red and

is so obsessed with it that she often sees red dots before her eyes and a red tint on all objects. This latter symptom might be called erythropsia, but that hardly explains it. It is impossible to put her to sleep or obtain from her any information about her attacks and her horror of red. During an attack, I hear her say: "Take it away, take the bier away, shut it, I don't want to see her head, oh! that bunch of red flowers, take them away." I would always tell the patient during an attack that I was going to remove the red flowers, and she would respond: "No, they're all there. — Well then! I'm adding violets. — I want white." And the conversation begins. For a long time it was impossible to induce somnambulism in Gu. by any other means than by this procedure.

By thus observing that the somnambulism of these patients is nothing more than a slight transformation of the attack, we will not be surprised to note once again a fact we have often described. The subject in this state often remembers perfectly the details of the attack, whereas they have completely forgotten them when in the waking state. The previous patient, Gu., explains to us very well during somnambulism how her attack is triggered by the reproduction of an old emotion dating back several years. She saw her father's corpse at the moment they were closing the bier, and at each attack she again sees this cruel scene. She also explains her horror of red through the memory of the flowers that were on the coffin. The pleasure or horror that hysterics feel when seeing red or other colors depends, in some cases, as is known, on fixed ideas associated with them.

These memories were just as clear during the somnambulism of Justine, induced in the same way. Great caution is needed when questioning her about cholera, for this question tends to reproduce the delirium, but it is possible to obtain all the information. The mind, far from being inactive during the attack, is on the contrary occupied with numerous and varied images that group together to form a more or less unified picture. These are, first of all, visual images: two corpses, one of which is especially visible at the forefront, "a poor old man all green, and blue"; olfactory images, a scent of putrefaction; auditory images: "the bells toll for the dead, one shouts: cholera, cholera"; kinesthetic images which manifest as cramps, cries, vomiting, diarrhea. All these images have a quite clear origin; they all represent the sensations that this woman may have experienced in relation to cholera.

Philosophers have often asked what an idea is, what exists in our mind at the moment we think of such and such an idea. M. Ribot recently conducted an inquiry of this kind on general ideas. This patient presents us with an interesting example of a certain kind of ideas. We see this now with the idea of cholera, which has, so to speak, reached the highest degree of perfection: a whole, a system of images drawn from all the senses, each one clear enough and complex enough to be realized, to become objective in the form of hallucinations and movements. Justine's attack is not a new phenomenon independent of these hypochondriacal preoccupations; it is the very idea of cholera itself which presents and realizes itself in a more complete form.

The abnormal aspect that this idea took on during the attack results solely from its excessive development. The idea seems to have isolated itself from the rest of life; it only develops at the moment when the patient loses consciousness

and seems to leave no memory afterward. In reality, this idea is accompanied by a certain consciousness and leaves a certain memory, but it is a consciousness and a special memory proper to this idea, which seems to constitute for it alone an entire psychological existence. The elements called forth by this idea are so numerous and so complex that they completely fill the field of consciousness and eliminate all other function and all other thought. This isolation of the idea of cholera contributes further, through a kind of vicious circle, to increasing its strength, and the images develop freely in hallucinations and movements. In a word, the singular characteristics of this attack are the consequence of the extreme development of the fixed idea.

We will furthermore find an easy verification of these relations between the attack and the idea if we succeed in slightly diminishing the power of this thought; we will see it reduced to ordinary proportions and appear once again as a simple idea.

How can one tackle such a fixed idea, which, despite all treatments, had grown in such an excessive manner over twenty years? We may, in this regard, discuss several psychic therapeutic methods that have been proposed. Two German authors, Messrs. Breuer and Freud, have reproduced—much to our satisfaction—our earlier studies on subconscious fixed ideas.³ They observed, as we did, that serious incidents were caused by fixed ideas that the subject could not express, that they were entirely unaware of. The existence of such ideas could only be revealed during attacks, dreams, somnambulisms, or by subconscious acts and automatic writings. In short, these ideas remained below or rather outside of normal consciousness. Messrs. Breuer and Freud concluded that these ideas were dangerous precisely because they were hidden and not expressed outwardly in a sufficient manner. To cure the patient, it would suffice to facilitate the external expression of these fixed ideas; if the subject could say their fixed idea during somnambulism, they would be healed. There is indeed some truth in this assumption: many patients with subconscious fixed ideas experience great pleasure in expressing their thoughts aloud during somnambulism or automatic writing. It is a sort of partial relief, even a partial cure, as one has sometimes observed. But this is unfortunately not always the case, and seeking to heal fixed ideas by this method is not always successful. But in the case at hand, Justine does not fail to express herself: doesn't she constantly express her fixed idea of cholera? Is a single word enough to relieve her? Will a cry suffice to dispel the inner horror? Can we consider this expression—the cry during the attack—as a cure?

Proper suggestion, pure and simple interdiction, can certainly be of some use. We do not believe, however, without doubt, that it suffices to say to a madwoman: "Go and be cured" to make her perfectly reasonable; but we believe that in some cases it is possible to gain some hold over automatic phenomena. One can, as I indicated earlier, surprise the subject by provoking varied hallucinations, by diverting her thoughts through subconscious movements, etc. These first suggestions succeed easily and provoke no resistance, if one begins without

³ J. Breuer and S. Freud, *Ueber den psychischen Mechanismus hysterischer Phänomene* (aus *neurologischen Centralblatt*, E. Mendel, 1893, n° 1 and 2).

directly attacking the delirium itself; one can then try to struggle with some success against the fixed idea itself. These methods had allowed me to transform the attack into somnambulism, to halt the idea of cholera in its development, to keep the patient in a more reasonable state, when she had been in her delirium. This influence persisted for a few days, and when Justine had left me, it sufficed for her to think of me, or for me to appear to her in spirit, for her to perform some gesture and the attack would stop. But it must be admitted that the automatic idea of cholera remained more powerful than my suggestions; she was rid of it for a time, and after one or two days, the cholera-like attacks reappeared, a little less violent perhaps, but just as numerous.

Let us therefore try another method—slower, more indirect, but perhaps more powerful. The fixed idea appeared to us to be a construction, a synthesis of a very large number of images; instead of attacking it as a whole, we must try to *break it down*, to destroy or transform its elements, and it is likely that the whole will no longer be able to persist. This is an application to therapeutics of the well-known axiom: “divide and conquer.” For some time I occupied myself only with a single element of the attack—contractures, for example, or olfactory hallucinations. Various suggestion methods here had an easier success and managed to remove such and such an element from the attack.

Other elements—visual hallucinations, for example—remained indestructible; instead of suppressing them, I confined myself to modifying them by a kind of *substitution*. Thus I tried to change the appearance of the corpses and above all spent several sessions dressing them. The hallucination of one garment, then another, succeeded fairly well; finally, the main corpse appeared outfitted in the costume of a Chinese general that Justine had seen at the Exposition. The success was especially complete when I managed to make the Chinese general rise and walk—he was no longer terrifying and added to the attack a comic element of the happiest effect. There is no need to recount in detail the many similar transformations, all aimed at the same goal: to break down the idea of cholera and render it unrecognizable. Under this influence, the illness transformed very rapidly, the crises became very incomplete and no longer involved vomiting or diarrhea, consisting instead only of a few cries mixed with bursts of laughter. A curious thing, though one I have frequently noted: the attacks ceased to occur during the day and appeared only at night. It seemed, if one may make this assumption, that the subconscious idea of cholera was too weak to appear amid the sensations and thoughts of the waking state, but that it developed more easily during sleep. Justine, during the night, had movements of terror, convulsions, called for help, etc. A more advanced dissociation, the substitution of suggested dreams, further reduced these nightmares, and the illness seemed considerably diminished—at least in this first form.

The benefit was, however, minimal, for the illness had transformed and now appeared just as formidable under another aspect. At the time of her major attacks, Justine was ill in an irregular and intermittent way. When the attack ended, she was relieved and calm for several hours, sometimes for a day or two. Moreover, she was only vaguely aware that she was ill—she vaguely knew that for a long time she had been tormented by the fear of cholera, but she no longer spoke of it

and no longer even thought about it in conscious awareness. In fact, from the moment the idea emerged, she remained conscious for only a few moments before immediately having an attack, with subsequent loss of memory. Since the attacks had disappeared, Justine was almost always aware of her condition, but her reality had become in fact much more miserable. The idea of cholera was more subtle, complex enough to suppress the personality, and it developed without leading to an attack, without provoking loss of consciousness or memory, in such a way that she remained conscious and was continually obsessed by the illness. “I no longer have,” Justine says, “those great fears that made me faint or gave me those attacks, but I think often about cholera, I have nothing but the *idea of cholera*, but I have it continually as before.”

This distinction may appear subtle, yet it is very important from both a psychological and a medical point of view. The attack, we said, with all its array of movements, physiological disturbances, and hallucinations, is nothing but the development of the idea. It is not a new or extraordinary psychological phenomenon; it only reveals to us the elements contained within an idea and which are probably contained in all ideas. It shows them to us with exaggeration, but without transformation of nature. This identity of nature between the attack and the idea is shown to us by the clinical evolution of the illness: at the moment when we remove from these elements their excessive intensity, they regain their natural aspect, they form nothing more than a simple idea. Moreover, in medical classifications, there is a tendency to separate patients who have attacks with loss of consciousness and memory from those who are obsessed by ideas while retaining consciousness and memory. We have already pointed out several times how closely related hysteria and psychasthenia are, how comparable their symptoms are psychologically.⁴ “The motor exercises using visual images,” let us say regarding Marcelle, “had a strange and rather poor result. In fact, the movements were done much worse, the arms were extended straight with an anesthetic rigidity; in place of dissociation due to aboulia proper to neurasthenia, I was no doubt developing hysterical anesthesia.”⁵ The study of Justine adds yet another argument to our demonstration: we clearly see the attack (a symptom of hysteria) disappear and become the obsession (a symptom of psychasthenia); we could give many other very suggestive examples showing the reversal of obsessions into attacks and attacks into obsessions, or even into hysteriform states.⁶ It is very likely that the attack is only a secondary form that the fixed idea takes when it can no longer remain in the state of conscious obsession. Such is likely the transformation that occurred in Justine, who remained consciously obsessed for a long time after the end of the attacks we have just studied. This new form that the fixed idea took is not another illness, but simply a new mode of the same one.

What does this idea of cholera consist of, which now remains in Justine’s mind? The former constituent hallucinations have disappeared; there is no more odor, no more corpses, no more sound of bells. What remains? First, a vague

⁴ *Archives de neurologie*, July 1891, p. 22, and *Accidents mentaux chez les hystériques*, 291.

⁵ *Revue phil.*, 1891, I, 393.

⁶ *Accidents mentaux*, 189.

emotion—that is to say, a set of sensations throughout all parts of the body: cold, shivering, nausea, etc. But this very real emotion seems, according to the patient's repeated statements, to come second: "I think of cholera in spite of myself, I have the idea, and that is when I am afraid." Such emotions—vague terrors that seem without reason—are very often described in the insane; but often, in our view, it is easy, through more serious examination, to detect the fixed idea more or less conscious that sustains, at the bottom of the subject, this emotional state. Recently, we were fortunate to study an interesting patient with persistent emotions without intellectual phenomena. Cas., indeed, after her delivery, was in a state of continual terror, a veritable panophobia. She trembles especially when she sees someone approach her, yet claims to be afraid of nothing, to think of nothing. When the patient was isolated and examined with care, we had to abandon this first interpretation. For, during her major terrors, she had visual hallucinations of which she retains a very imperfect memory. During her pregnancy, she was beaten by her husband completely naked, and since then she retains, as a suggestion, the image of this scene which is renewed when someone tries to enter the room. This is thus one of those fixed ideas as we have always observed them. We certainly acknowledge the existence of pure emotions without intellectual phenomena at their origin; perhaps they can be observed in other pathological states. But we believe it is right to demand a somewhat more precise analysis of cases where they are observed.

In the patient we are studying today, that is, Justine, the emotion of terror seems clearly provoked by an idea, just as she herself says. But what does this idea consist of, when its essential elements seem to have been erased? Only one last element remains to be discovered by elimination: it is the *word*. Once attention is drawn to this point, it is very easy to observe again and again the role of language in obsessions. When Justine is motionless, seemingly engaged in some sewing task she performs mechanically and is not truly doing, she constantly stirs her lips and murmurs a somewhat easy-to-identify word: the word "cholera." She engages in automatic writing when prompted and can, upon command, write different things, but she also has writings of this spontaneous kind, and when she holds a pencil in her hand, she indefinitely scrawls the word "cholera." When she neither speaks it nor writes it, she hears it; it is interesting to note that this patient has very distinct auditory verbal hallucinations. The voice is externalized, with variable tone. "It is several voices mixed together, you'd think it was a crowd screaming after me." But she mainly has these kinesthetic verbal hallucinations or verbal hallucinations of Mr. Séglas' type, which we have already emphasized. "It is my head that says the word cholera, it is not me."

She has in this regard a very clear feeling of the splitting of personality. "When it's me who says the word cholera, I know it very well, I'm less frightened, but what makes me sick is when *something* says it in spite of me." We are dealing here with a patient obsessed by the *word*, the last remaining element of a more complex representation. This obsession was no less serious; it maintained all the disorders of thought and was capable of gradually recalling all the former hallucinations.

To make this last symptom disappear, we used the same methods of division and substitution, which we will briefly recall. I transformed the word *cho-le-ra* by suggestion into the name of the Chinese general. I let the automatic writing hand begin with the first syllable *cho*, then I guided it and made it finish the word differently. I got her to write ridiculous words, absurd combinations of syllables: *cho*, *chos*, words beginning with *co*, as in *cotton*, *coqueluche*, *cocorico*, etc. This last term even became a spontaneous hallucination, so much so that the patient sometimes saw objects appear as soon as she began to write *co*. We do not dare to insist here on the description of these methods and especially on the language games that sometimes appear a bit childish. We lack above all the practical exercises to further decompose and destroy obsessions. For example, Justine had begun to become disturbed by the very object she associated with her hallucinations, namely a cotton garment that had belonged to the cholera corpses. She would say: “Which one is it? I don't know anymore. I've been trying for eight days, if I separate it, I can't put it *back together*, it's co... cotton, no, it's not the right one, it's a strange word. What does it mean?”

No doubt, there were fluctuations; from time to time an incident—the sight of a dying person, the smell of phenol, etc.—would bring back the idea of cholera by association. But these memories became increasingly rare. Naturally, I avoided questioning the patient on this point and had strictly forbidden any conversation capable of reviving the memories. I was astonished to see how complete the forgetting had become: at the time of the last cholera epidemic in Paris, Justine asked out of curiosity what this disease was, and this woman who had had such delusions about an imaginary cholera mocked people who were afraid of the real cholera. Only very rarely, twice in two years, did the fixed idea and the terror seem to reappear for a moment in response to incidents we will speak of later; but they were quickly erased and forgotten.

I believed I would have to actively erase the various accessory hallucinations that had helped me decompose the fixed idea, but in reality they faded gradually and spontaneously. This disappearance allowed the patient to acquire once again a vague idea of cholera and a very confused memory of her former illness. She speaks of it without emotion, but also without being able to remember what actually took place.

The treatment I have just summarized lasted ten months; that would not be too long to destroy a fixed idea as intense as the one that had lasted twenty years, if we could consider the patient as cured. Unfortunately, many other symptoms remain that will take away our illusions.

II. Secondary Fixed Ideas

For the clarity of our exposition, we gathered in the first paragraph all the facts relating to the fixed idea of cholera; but, in reality, these facts did not exist in isolation. A large number of other pathological phenomena and even other fixed ideas were constantly mixed in. From the moment the idea of cholera began to diminish, and especially when it disappeared, other fixed ideas arose—numerous and menacing—which strangely came to complicate the study and treatment of

the patient. We have already designated these phenomena under the name of *secondary fixed ideas*; we have often mentioned them, for they form the principal obstacle to the therapeutic treatment of mental illness. To forget them, to barely mention them in clinical descriptions, is to misunderstand the essential character of the illness; to limit the disorder to a single fixed idea and to believe that it is enough to remove it by suggestion is to have only a completely incomplete notion of an illness whose deeper nature is much more serious and extensive.

These new ideas bear the same general characteristics as the first: they are foreign to the personality, imposed on the will, and often absurd in content or expression; they give rise to obsessions, to irresistible fears, to incoherent acts; they are constantly tormenting the patient and lead to increasingly complete disorganization of psychic life. It is true that they are at first more unstable, more fleeting, but gradually they become fixed, crystallize, transform incessantly, and become very numerous and very varied.

To describe the innumerable secondary ideas of Justine, it is useful to divide them into three groups, following a fairly natural and convenient classification that we have already proposed:⁷

(1) Secondary fixed ideas by *derivation*, or by *association*. Some of these ideas simply appear to be elements detached from the primary fixed idea, or at least they are easily connected to it by links of consequence or association. However, these fragments of the primary idea can develop independently and may even survive after the disappearance of the original idea. Here is a very good example taken from another patient. Ger..., a young woman of twenty-eight, attended the sudden death of her mother alone, held the body in her arms, and this event seemed to have struck her profoundly. Since then, she reproaches herself with criminal feelings toward her mother-in-law, accuses herself of her death, imagines that she killed her, and wants to be condemned and executed. This is clearly a primary fixed idea of guilt and punishment. A suitable treatment succeeded in suppressing the fixed idea of this young woman, and I believed her cured, when one day she entered a new delirium. She wanted to kill her child, to strangle it, because for the past four or five days she had felt a growing and terrifying impulse pushing her to strike or kill it, while she found this impulsive movement entirely inexplicable. It was, however, a clear secondary fixed idea: "I must kill the child, because Ger... explains it by saying that it is her punishment." So we see: the first idea, that of crime and punishment, disappears, but it is not forgotten; Ger... no longer thinks of killing herself and no longer reproaches herself; the second idea, although derived from the first, has developed independently.

Ideas of this kind were very clear in Justine: for example, we would not be surprised if we were told that for the past ten years Justine has never wanted to eat a fruit or a vegetable—this is an all too obvious consequence of the idea of cholera. But with the idea of cholera almost gone, here is the patient who, without knowing why, stubbornly refuses all food: it is the consequence that has become isolated from the principle.

⁷ *Accidents mentaux chez les hystériques*, 182.

We consider, as belonging to the same kind, the numerous ideas and dreams relating to death. She dreams that she is occupied with digging up coffins, opening them, removing the corpses to place them in a wheelbarrow and transport them to another cemetery. By day, she cannot see a hearse without “piercing the planks”—that is, seeing through the boards the decaying bodies. Some authors have declared that patients obsessed with fixed ideas have no hallucinations; we cannot explain such a claim. These patients almost always begin with kinesthetic hallucinations that form part of their illness and very often, in our opinion, have hallucinations of other senses, when the disorganization of the mind is complete, or when their fixed idea takes the form we have called hysterical. To return to our patient: she has an appalling fear of hospitals and takes great detours to avoid passing by the door of the Hôpital Saint-Antoine. Finally, when she lost the idea of cholera, she replaced it with the fixed idea of another illness and thus gradually filled her entire pathology with it. She claims to have cerebral congestions and, following her habit, acts out the scene of a seizure. She is found on the ground, limbs limp, stertorous breathing, which cannot fail to be alarming, though it is less so than the first attacks. Then she comes to believe she has heart disease, smallpox, or breast cancer that she absolutely wants to have removed, etc. We can consider these ideas as forming a first group, the group of secondary ideas that still depend on the first fixed idea, that of cholera.

We observe, in these patients, a second group of secondary fixed ideas that we have already designated by the name *stratified fixed ideas*, because of the peculiar way in which they present themselves to the observer. When one removes a fixed idea, one is surprised to see another arise that has no relation to the first idea, nor to the surrounding circumstances. It is an old idea, anterior to the one just treated, that reappears. Once it too is removed, a third obsession appears that had previously existed, and one is forced to revisit, in reverse order, the principal fixed ideas that tormented the patient throughout their life. This reappearance of old ideas was very characteristic and very serious in the patient Marcelle, who was the subject of our first study; it seemed very clear to me also in other patients. But in Justine’s case, the secondary ideas of this category did not have great importance. This is because, in her, a single idea—that of cholera—almost always dominated without allowing space for other obsessions.

Only for a moment did she begin again to believe herself pregnant, but this thought did not last; her former angers toward her husband reappeared in a more curious manner. Justine is usually very devoted and very affectionate toward her husband; she realizes that she is an unbearable wife and tries to make amends. Suddenly, she changes her attitude and expression, becomes somber and refuses to speak to him, turns pale, and in a harsh tone begins to reproach him. Within moments she becomes agitated and overwhelms her husband with every possible insult; she screams just as much as in the attacks caused by her fear of cholera; she wants to run through the streets to seek a lawyer, etc. The attack gradually calms, and Justine retains only a very vague memory of what just occurred. She must be put into somnambulism to learn that the idea arose at the moment Justine was kissing her husband: she thought she might bite him, and this thought reawakened the old idea of hatred and divorce. The husband confirmed to me that

since the disappearance of the idea of cholera, Justine sometimes again displayed exactly the same temper, the same fits of anger she had at the beginning of their marriage. It is clearly an old fixed idea that has reappeared.

It is necessary, in our view, to establish a third category of secondary fixed ideas, more prominent in our patient and much more interesting for pathological psychology: these are *accidental fixed ideas*, formed by suggestibility. Justine, freed from her old fixed ideas by the methods previously described, remained calm for only a very short time. Soon she was prey to a new obsession. It was not an old idea, nor a remote consequence of the original idea of cholera. No, it was a new and absolutely random idea, provoked by any minor event in life. A worry, an emotion, a dream, a word overheard by chance would provoke a thought which, after a few days of incubation, would grow and again invade the entire mind.

It is impossible to list all these accidental ideas which, for a year, tested our patience; here are a few taken at random. Justine had the idea of throwing herself into the water, because the water attracted her; of throwing herself out the window, because the house tilted to one side; the idea of strangling her dog and hanging her birds; the idea of throwing her food on the ground or at the heads of people who entered. She stubbornly refuses to wear a hat to go out, refuses to change her chemise (she puts on clean laundry in front of her husband who forces her to, and as soon as his back is turned, she undresses and puts the dirty linen back on), she will not turn on any lights, for fear of setting fire to her dress and to her house, refuses to buy anything at the market, for fear of stealing, refuses to do housework or touch anything in her room. She is obsessed with the idea that her piano is bad and not worth the minimal price it was paid for (terrible scenes for several weeks); she is tormented by the memory of having refused, ten years ago, a cup of herbal tea to her husband, by the regret of a small flask she broke and over which she weeps day and night. Then it will be the fear of lying and the conviction that she lies constantly, the hatred of a young apprentice, a disordered love for the neighbor's little dog, which leads her to commit a thousand extravagances, etc., etc. Instead of a single, unique fixed idea that had ruled for twenty years, we now found ourselves in the presence of a swarm of little fixed ideas, constantly transforming and renewing themselves.

To show the seriousness of these accidental secondary ideas, I will insist on a few of them that took on interesting forms. Justine is preoccupied with a piece of music she is studying, and from that moment she notices that she no longer sees clearly, because there is a dusty veil in front of her eyes. On closely examining this "dust," she discovers with astonishment that it is the musical notes of her piece that constantly move before her and prevent her from seeing enough to walk on the street: here again is a visual hallucination. She read a few pages of a novel by Eugène Sue in which one of the characters is very proud. She so fully enters the skin of this character that she believes people are reproaching her for his conduct and his pride: this is an auditory hallucination. She is afraid of being scolded, and we frequently observe this among patients who speak constantly without disturbing their attention; but in Justine, this idea manifests as an inner voice that reproaches her for her dishonesty. "It's the same voice," the patient

herself noted, “that once said ‘cholera, cholera’”; one recognizes the old kinesthetic verbal hallucinations.

In other cases, fixed ideas will provoke subconscious movements. Preoccupied with a change of residence, Justine dreams every night that she is moving; she makes movements during her sleep and in the morning wakes up with her arms and legs contracted. These contractures are particularly interesting—they are clearly systematic. Not all muscles are equally tensed; they are tensed to different degrees in such a way as to hold the limb in a rigid but expressive position. The arms are in front of the chest, half-bent as if bearing a heavy object; one of the legs is extended on the thigh with the foot resting on the leg, the other leg is half-bent: it is the position the lower limbs take when climbing stairs. These contractures relax during somnambulism when Justine can explain her dream and modify it. Moreover, she frequently had contractures of this kind following dreams that occurred during the night or even during the day. She dreams of walking upside down and contracts her arms in extension above her head, she dreams of climbing trees and her hands become clawed, she especially dreams of her piano and of the difficulty of playing an octave, and here are both hands frozen in place, fingers stiff and spread to the maximum as if to reach the octave.

These systematized contractures are not observed frequently, not because they are truly rare,⁸ but because they usually do not retain that form for long. Little by little, all the muscles contract further and the limb takes on the classic position of generalized contracture. Subconscious phenomena are, as we have shown, very invasive; they do not remain limited, but quickly grow and suppress or alter other psychological facts that appear unrelated. Thus anesthesia spreads, the amnesia of somnambulism takes hold, and the moments preceding the secondary state are forgotten just like the somnambulism itself. To observe very clear subconscious phenomena—and particularly these systematized contractures—one must be able to observe them from their onset.

These accidental ideas also produce attacks, and we will report in this regard an incident that caused us quite a bit of concern. Justine, who seemed fairly well, had gone that morning to take a shower at the hospital, and came back with a dark air that signaled some storm, but she could not explain what was troubling her. Around three in the afternoon, she entered into a furious rage and, armed with a kitchen knife, ran after her husband to stab him. In a moment of consciousness, she cried out: “Save me, I’m going to kill him,” then surrendered to delirium. It took three men to restrain and tie her down. Immediately alerted, I was deeply grieved to see this kind of madness I had tried so hard to push back gaining more and more ground, and I believed immediate internment was necessary. However, I soon realized that this new fixed idea, though terrifying in appearance, was no different than the others. That morning, in the shower, a woman had told a brief story: a patient she knew had once been confined in an asylum because she wanted to kill her husband. That was enough—Justine had meditated on those words all day, and then had in her mind only that single idea: to kill her husband with a knife, and that idea had filled an attack just like the idea of cholera had

⁸ *Accidents mentaux des hystériques*, 109.

once done. This dangerous fixed idea was fortunately easy to erase, and Justine regained her tranquility—at least for some time.

It is indeed easy to observe that all these secondary ideas—especially those of the last group—could, without much difficulty, be erased. A session of somnambulism to clearly recover the initial image, some suggestions, some dissociations easily overcame them. This is largely due to the short prior duration of these ideas. Fixed ideas are in fact like contractures; M. Charcot rightly observed that one should not let contractures linger, and likewise one should not let fixed ideas develop. The closer they are attacked to their origin, the easier they are to break down and destroy.

But this observation did not advance the cure of our patient. What good is it to have the power to quickly remove a fixed idea, if she takes up another a few moments later? This swarm of fixed ideas, like parasites on a dying tree, is in her nothing more than the effect of greater damage. It seems that the mind was deeply disturbed by the initial obsession and that it is now incapable of resisting the development of even the weakest idea that might arise in it. A peculiarly apt comparison helps us to understand this state and its dangerous character: we know that our organs are normally very resistant to infections; although many and varied microbes are constantly deposited on the orifices, they do not penetrate into the body, as the mucous membranes remain sterile. This resistance of the organism to infection has many causes, but under certain conditions it is overcome. A particularly dangerous microbial species seems to initiate the primitive infection of the organ. From that moment on, a very curious phenomenon arises, which was particularly highlighted by M. Jules Janet,⁹ in regard to a special organ. Once the primary infection is cured, the organ does not return to its previous state of resistance and immune defense; it remains, on the contrary, for some time—a rather long time—in a *state of receptivity*, that is, it allows itself to be infected very easily and at any moment by this or that ordinary microbe which previously had no effect on it. These secondary infections in organic pathology do not seem unrelated to the secondary fixed ideas of mental pathology. We see from both sides that the illness is not over with the infection or the primary fixed idea; the receptivity that remains gives rise to endlessly repeated relapses. Each of these relapses is dangerous: it is easy to see, returning to the subject that concerns us, that each new fixed idea can take root and grow and very quickly constitute an illness just as serious as the first. It is even possible that one of these new ideas could by association reawaken the first and cause the patient to fall back into the very state from which she had emerged. The cure that cost us so much time and effort is thus very much in jeopardy and does not seem to have been as complete as we had hoped.

III. Suggestibility and Aboulia

The accidental fixed ideas we have just studied are not, for us, an unfamiliar phenomenon; they are entirely identical to phenomena that have been thoroughly

⁹ Jules Janet, *Réceptivité de l'urètre et de l'utérus* (*Annales des maladies des organes génito-urinaires*, August 1893).

analyzed in experimental studies—suggestions. In both, we find the same development of the sensory and motor elements contained in an idea, the same isolation of the thought that detaches itself from normal consciousness. This is a supposition easily verifiable in our patient.

Justine was, from the very first days we knew her, remarkably suggestible. It suffices to raise one of her arms in the air for her to forget it in this strange position; soon the limb contracts *in situ*, which gives us the experimental reproduction of systematized contractures. A word, during her most normal waking state, provokes all the hallucinations or determines dreams which will be accompanied by spontaneous hallucinations. These suggested ideas develop with force and completely outside her normal personality. It would not be wise to walk in her path and try to stop her after having given her a suggestion; she also becomes violent, just as little conscious as during her natural attacks. The memory, moreover, is quickly lost after these suggested acts, just as with fixed ideas. Finally, it is easy to provoke all kinds of subconscious acts, writings, and even fully automatic words that she utters without realizing it and without being able to stop them, as she once murmured the word *cholera*. The very production of these accidental fixed ideas (a word heard by chance, a newspaper clipping she read, etc.) is the same as that of suggestions, and one can conclude by uniting the two phenomena under a single term: it is to the extreme suggestibility of this woman that the endlessly re-emerging fixed ideas are due.

Certain authors have not hesitated to affirm that suggestion is not a phenomenon specific to certain patients and that we are all suggestible. This opinion likely arises from certain confusions of language, for under the name of suggestion one often conflates all the mechanical phenomena of thought—memory, association of ideas, habit, etc. But if we restrict the word *suggestion* to a precise meaning—the complete and automatic development of certain ideas outside of the will and personal consciousness—we will be forced to admit, we believe, that suggestion is a clearly pathological phenomenon. In any case, the example of Justine seems to us instructive: here is a truly suggestible person, and we have seen what consequences suggestion brought about in her. Are we all so similar to this woman? Do we have, at every instant, within us, ideas as fixed as those that suggestion produced in her? Obviously, it will be agreed that there is some difference between the suggestibility of a normal man and that of our patient; one will have to acknowledge that there is at least a considerable difference of degree. It is this difference that we are trying to understand by seeking, in the other disturbances of cerebral functions, the reason for this abnormal suggestibility.

Many other disturbances, in fact, became mixed with the fixed ideas that we have described in isolation. Let us first note certain accidental and transitory phenomena that one could also call attacks, but which seem to us quite distinct from the attacks previously described. From time to time, especially during periods of discomfort and fatigue, or following work that required some attention, she would stop moving, her eyes fixed, her mouth half open. She would remain this way for hours on end; when spoken to, she would respond with meaningless words or with questions: “Where am I? I don’t understand anymore,... I no longer

know,... my head is empty,... I'm dead..." Instead of resisting with rage, as she ordinarily did during her attacks, she would let herself be led docilely and would obey very simple commands: "Come, sit down..." But she would soon fall back into her stupor. This *stupor* lasted in her only a few hours; only once, to my knowledge, did it last two days. If one investigates, using the methods previously described, what "filled" her mind during this attack, no specific idea is found, only very vague dreams: "of people moving about, fighting, carriages passing overturned, with horses in the air..." Most often, in fact, there is no dream; Justine thinks of nothing, perceives and understands nothing anymore, she is in a "blank state" and feels "as though no longer living, as though already dead."

This attack of stupor is very significant; in many respects, it is identical to those "states of mental confusion" that have recently been described following infectious diseases. But here, this mental confusion is not an accidental or "primitive" event; it is a momentary exaggeration of a state of general weakening which, in this patient, is continuous, and this absence of perception is only the final degree of the attention disorders that have existed throughout the patient's life. The various syndromes that have been described under the names of neurasthenic state, aboulia, mental confusion, or stupor merely represent the various *degrees* of one and the same psychological disturbance, and the patient can easily pass from one to another under different influences.

We are now going to find in Justine all the symptoms that we have described in other patients under the name of "aboulia" phenomena. It is interesting to see once again their characteristics and to observe that they still accompany fixed ideas and suggestibility. We will study these phenomena in the will, in attention, in memory, and in the perception of sensations.

We have, until now, only seen Justine in her "attacks" and found her agitated and violent. She is completely different in the interval and especially much calmer, for she has long been absolutely incapable of doing anything. She is like a child without will or resistance, acting somewhat under the continual impulse of those around her, and often even incapable—despite her efforts to obey them—of doing so: "I would like to work, but I don't have the courage to get up, to manage... Getting out of bed, out of a chair, is work that isn't human." As we know, she can continue work indefinitely once it's begun; but she cannot interrupt it to start a new task. She once spent an entire day sewing buttonholes without being able to get up to go eat a little. We will not dwell on these facts, nor on the slowness and hesitation of voluntary acts as opposed to the brutality of impulsive acts; these are now well-known facts.

Attention is absent, which disrupts all understanding of present things. Of course, Justine reads without comprehension; this is a truly characteristic symptom of these patients. "There is, between me and your newspaper, a monstrous obstacle, a thick fog..." Let us not take these words too precisely: the patient sees clearly and distinguishes the letters she spells out quite well; it is the synthesis of the words that she is incapable of doing. This deficit of attention even affects the perception of objects; she no longer recognized the people who came to see her and asked her husband how to use the most common objects. She poorly understands language, no longer has any confidence in what is read to her,

and ends up doubting her own words: “Did I say something stupid?... I must have lied, right?” These inaccurate perceptions astonish her, and she complains that things are no longer as they ordinarily are: “The world has changed... I no longer recognize it...”; a fog envelops things, and people speak to her through a wall.” It is truly curious to observe how much all these patients resemble one another, how “the emptiness in the head, the fog, the wall” are characteristic expressions that can almost be considered as symptoms, for they are found exactly the same in all observations.

Memory exhibits very complex disturbances; certain amnesias are clearly systematized. For example, Justine forgets the appearance of her husband, who had been away for a few hours, to the point of no longer recognizing his portraits. We have already described some of her systematized amnesias that pertained to language. “Justine loses the motor memory of certain words, she hears them but cannot pronounce them: her husband must articulate them clearly in front of her so that she can see the movement of his lips and try to reproduce it. When she is alone and wants to pronounce these words, she must evoke the visual image of her husband’s lips to imitate the movement. She frequently forgets how to write and suddenly no longer knows how to begin a word, or she writes it with a fantastic spelling, or simply skips it.”¹⁰ These small lapses in speech or writing in a hysterical patient are clinically interesting, as they sometimes very closely resemble the characteristic forgetfulness of paralytic dementia.

Other localized amnesias were produced by the attacks and by the somnambulisms. All the phenomena grouped around subconscious dreams were thus carried along with them and attached to this second existence. These amnesias, however, showed in Justine an interesting and already often noted irregularity. The forgetting was complete upon awakening from somnambulism, but the next day and in the following days, some memories of the second state would reappear during waking. This return of memories can be explained, depending on the case, in different ways; it is due, we believe, to the fact that the subject dreamed during the night following the somnambulism session and partially remembered these dreams, which became a kind of intermediary between somnambulism and waking.

But the most significant disturbance of memory was what we have designated by the name *continuous amnesia*. Justine remembers old facts well, especially events from her youth, but retains recent memories poorly. This forgetting once took a clear form at her home: her husband had bought her a piano; for a long time, she would stop in front of this piano without knowing where it came from. “The other pieces of furniture,” she would say, “I know them well, but this piano, where did it come from? Who put it there?” Despite apparently very great efforts, repeated over several days, she could not manage to learn a few verses and recite them by heart. These amnesias exist in reality only for the conscious person—the memories, as we will see, persist in a subconscious way. During the attacks and somnambulisms, Justine recited very well the verses she had tried to learn.

¹⁰ *Stigmates mentaux des hystériques*, 1892, p. 85.

Finally, this form of amnesia is connected with disturbances of attention and conscious perception: we cannot return to that study here.¹¹

Finally, this psychological insufficiency manifested itself in a manner, if not more decisive, at least simpler, in the disturbances of conscious sensibility. Anesthesias of the various senses existed at the beginning of observation and were reproduced under various circumstances: complete anesthesia for pain; touch and movements transmitted on the left side, analgesia on the right side, anesthesia of the tongue, loss of taste, loss of the pharyngeal reflex, nearly complete loss of smell, diminished hearing, reduction of visual acuity to 4/8, narrowing of the visual field to 70 on the right side and 35 for the left eye. But it must be acknowledged that these anesthesias were extremely variable and changed under all sorts of influences. They seemed to disappear as soon as the fixed ideas diminished and reappeared with each new obsession. This anesthesia corresponds exactly to the type we have described under the name of anesthesia by distraction; it clearly shows us how the anesthesias that are more stable in other hysterics are formed.

Most often, a diminution, a disturbance in sensations was observed rather than their complete suppression. These disturbances were especially curious with regard to the visual sense and gave rise to several interesting observations.

The first of these visual disturbances is, in my opinion, often linked to what is commonly described under the name of *asthenopia*. When the patient looks with fixed attention—when she tries to read, for example, or to understand—she can see clearly for only a short time; after about two minutes, she complains of pain in the eyes, in the bridge of the nose, she has tears in the left eye, then in the right eye, she sees less and less, and finally finds herself in an almost total darkness. This stoppage of vision lasts about two minutes, then sight returns in the right eye, then in the left. If the patient continues reading, the same event occurs again after a few minutes. Is such a phenomenon essentially visual—is it due to disturbances within the eye itself? We do not think so. Indeed, we observe a very similar phenomenon in the sense of hearing when it is exercised with voluntary attention. We ask the patient to listen to the ticking of a watch or the beating of a metronome, and she can only do so for a short time. She stops, begins to groan, complains of ear pain, and no longer hears anything at all; hearing only returns after a rest, and again disappears if the patient tries to listen attentively. Furthermore, this phenomenon does not occur in dreams, where everything suggests that the sensation is both attentive and voluntary, for she remains for a long time with her eyes open, but she sees nothing, and yet later can recount in great detail everything that was happening; she was paying attention without realizing it. During this attentive effort, she no longer saw the letters, no longer understood what she was reading, and her eyes became like blind every two minutes. She truly sees, since in a moment of rest she resumes the sentence at the correct place. This *asthenopia* is thus a particular manifestation of the failure of attention that we have already pointed out, especially the visual phenomena which, for a short time, tire her rapidly.

¹¹ *Amnésie continue*, (*Revue générale des sciences*, March 30 1893, p. 167).

Another alteration of vision is also related to the insufficiency of attention—these are the modifications of the visual field. Justine's visual field is extremely variable; it narrows enormously as soon as the subject experiences physical or moral fatigue, and especially when she is obsessed with fixed ideas; I have already shown elsewhere that one could follow the severity of the fixed ideas of this patient better by observing her visual field than by taking her mental state. Even when the visual field is very large and seems normal, it still presents a latent alteration which only becomes evident through experimentation. “At the center of the apparatus, I fix a piece of paper on which, in some cases, I write a few fairly short phrases or words. I then place the patient in the desired position to measure her visual field and ask her to mentally perform an arithmetic operation while reading the words inscribed. When attention is fixed on this operation, which ordinarily does not prevent one from reading the words written at the center, the patient can no longer see them. If I then draw a small white object on the perimeter, from the outer side toward the center, she perceives it only when it reaches the center; for example, I start from the periphery toward the center and she sees it only at the 40th degree, then I do the same on the other side, and she perceives it only at the 30th. If I now signal her to advance toward the center, she sees it only at the 15th or 20th degree. Following this response, I repeat the same operation without asking her to perform the mental calculation, and I find it very easy to determine the visual field of the subject paying attention to the reading.”¹² We have thus noted in several experiments that the reduced visual field of the normal man, although already significantly smaller than that of our patients, drops under these conditions from 90° to 30° and sometimes to 20°. The field of personal perception is so small that it cannot focus on one point without abandoning the others, and it is because there are more details to perceive at the central point that the peripheral visual field diminishes. This narrowing of the visual field due to attention belongs, moreover, to a group of similar phenomena, for one can easily observe a momentary anesthesia of all other senses at the moment when the patient pays attention to a particular sensation. The diminution of the power of synthesis, the narrowing of the field of consciousness, clearly affects here the number of *simultaneous* phenomena, while in the previous observations of asthenopia it seemed to affect duration, the number of *successive* phenomena that could be consciously perceived.

Finally, we will only point out one last visual disorder, the study of which would require lengthy developments: monocular and binocular diplopia. The patient sees double; but what is astonishing and contrary to all the laws of optics is that she sees double even when only one eye is open. Without reentering here into the delicate discussions related to this monocular diplopia,¹³ we will only recall the conclusions. “The accommodation disorder that accompanies monocular diplopia and which was studied by M. Parinaud is the starting point of an illusion; the patient sees troubled and non-double reality in all objects that are not precisely at the point for which her eye is accommodated. It is through a habitual hallucination, by a fixed idea, that monocular diplopia arises.” But where

¹² *Stigmates mentaux des hystériques*, 76.

¹³ *Accidents mentaux chez les hystériques*, 73.

does such a fixed idea originate? It comes, in the present case, from binocular diplopia which is real and one of the most interesting phenomena for the psychological analysis of these patients.

When Justine has both eyes open, she sees two images, each one provided by one eye; this can be verified by covering one eye with a colored glass—one of the images appears tinted red while the other remains white. This diplopia is partly due to a misalignment of the optical axes and to a true momentary strabismus. But this failure of convergence and this strabismus are themselves only a deeper consequence, that is, the failure to merge or synthesize the different images supplied by the two eyes.¹⁴ This feature is very common among hysterics; it has been frequently observed even before it happened with Justine. In fact, patients soon stop abstracting from the images supplied by both eyes; they let them persist subconsciously, and when they have both eyes open, they consciously see only what one eye sees. They instinctively substitute monocular vision for binocular vision. It is easy to confirm this with a simple experiment: while they are reading a book, place a vertically positioned pencil in front of their two eyes that blocks certain letters; this would not happen if they were truly seeing with both eyes. This neglect of sensations from one eye seems to be at the origin of unilateral amorous blindness. One can, as Mr. Parinaud elegantly showed, consider that binocular vision is properly human and regard this as a regression and return to monocular vision similar to that of animals. One can especially observe that this visual disturbance completely confirms the ideas we have always expressed about the sensations of these patients: the failure of synthesis, the dissociation of functions is emphasized here perhaps more clearly than anywhere else.¹⁵

The principal disturbances we observe in our patient's will, attention, memory, and sensation are here briefly summarized. These disturbances of various functions combine, as one might suppose, to produce a general alteration of character and personality. Justine herself was aware of it, and she constantly repeated the stereotyped phrase: "I've changed, I no longer recognize myself..." Her overall character was primarily childlike: this forty-year-old woman had the astonishment and naiveté of a small child; she wanted people to play with her, to amuse her, and she would endlessly quarrel over trivial matters like a ten-year-old child. But she also displayed other bizarre traits, often inexplicable, all the contradictions that characterize the conduct and attitude of hysterical individuals. Her spirit was one of finesse, delicacy, and surprise, and yet at times she seemed completely coarse, indifferent to everything, without concern for affection or moral sensibility. This woman is astonished by her own character: "How can I be so hard? I am always sweet, I love everyone—I don't hate anyone." We have already tried many times to explain these contradictions, but perhaps it would be necessary to seek the solution in the weakening of the synthesis of psychic functions: the dissociation, the lack of coordination between intelligence and

¹⁴ Consult on this point the very interesting *report* by Mr. Parinaud *sur le traitement du strabisme*, 1893.

¹⁵ Our studies on the psychology of hysterics have led us to express ideas about their vision that are, for the most part, very similar to those of Mr. Parinaud. The apparent opposition, we believe, lies only in the language used. Mr. Parinaud expresses the facts in anatomical language; we believe we must limit ourselves to describing these facts as they are currently known—that is, in psychological language.

feeling, between feeling and will, between thought and the constant unity of the mind. But in closely observing these always interesting characters, we continually encounter new difficulties and new questions.

We cannot conclude this study without noting the physiological disturbances that accompanied these mental perturbations; they are equally characteristic and are found in most patients of the same kind.

We will not dwell on the digestive troubles, although at first glance they may seem considerable; Justine, who ate very irregularly, had painful digestion, vomiting, alternating bouts of diarrhea and extremely stubborn constipation. The stomach, however, was not dilated and did not show any notable alterations; these troubles seem to be tied quite directly to the fixed idea of cholera and the diet she followed; they disappeared very quickly and did not appear to accompany the other symptoms of the mental state.

The disturbances in general nutrition were, on the contrary, quite curious: we first observe, as in the case of Marcelle, dry and scaly skin, brittle nails, falling hair, etc. But we were particularly struck by a singular obesity: this corpulence is variable, it increases during periods of severe illness and diminishes when Justine gives up her fixed ideas and regains some will and energy for work. It has been this way, as we shall see, since the patient's childhood.¹⁶

Circulatory disorders, and especially disorders of the vaso-motor functions, are among the clearest. Bruises appear on the limbs following contractures brought on by dreams, red spots are frequently marked on the face, on the cheeks, and on the forehead, associated with sudden paleness, etc. These red spots on the nose, ears, and under the eyes are very common in neurasthenics and help characterize their physiognomy. But in Justine's case they were so mobile that they seem to be connected with the patient's perpetual emotions.

Menstruation has long been quite difficult and insufficient; this period is also always accompanied by a tremendous resurgence of all the symptoms. Not only do fixed ideas intensify at each occurrence, but it is above all at this time that the patient develops new kinds of fixed ideas. One cannot emphasize enough the enormous suggestibility of women during menstruation. It is, in my opinion, the unknown starting point of many nervous and mental illnesses.

Finally, the general disorder of the nervous system manifests through physical symptoms that we believe we must report. It is known that, in general, hysterical anesthesia and paralysis do not alter reflexes, for they are more often than not psychological symptoms; but independently of the anesthesia and paralysis, it may exist, we believe, in these patients, alterations of reflexes related to the general exhaustion of the nervous system. Not only had Justine lost the pharyngeal reflex—which is common—but she also showed very diminished or nearly absent patellar reflexes. Furthermore, the pupils are unequal, the right much more contracted than the left, and this inequality seems to be related to the weakness and insufficiency of the pupillary reflex on the left. If one adds that the

¹⁶ We were not able to analyze the urine in a sufficiently precise manner, as the patient was outside the hospital and only provided us with an incomplete record of the day's urine volume. We only observed that it did not contain any abnormal substances.

patient cannot stand with eyes closed, that she experiences vertigo and the very precise memory disturbances we have described, it is undeniable that many individuals would be inclined to affirm a very serious diagnosis. This would certainly be an error, as we have been able to confirm through long observation. These alterations of reflexes are variable, which is surprising, and the pupils often return to normal once the fixed ideas have dissipated and the mind has regained clarity. Moreover, as is well known, nothing is easier than to confuse these hysterical or neurasthenic states with organic paralysis. It is also worth repeating once more that reflex disturbances and pupillary inequality may not be decisive signs.

We do not seek to determine which of these psychological and physiological disturbances are primary and determine the others; that is a completely idle dispute. All these phenomena are just as important as each other, they form an inseparable whole from which nothing should be removed; they are all manifestations of a fundamental alteration that will probably remain unknown to us for a long time. The only thing that seems important to note is that in all these disorders there is a common characteristic, namely the dissociation of functions, the loss of unity, the diminishment of the continuous synthesis that gives rise to life and thought.

It is precisely this general characteristic that explains the suggestibility and proliferation of fixed ideas. Fixed ideas develop fully only because they develop in isolation. The mind and body as a whole no longer respond as they do in a normal person to each phenomenon; the disaggregation leads to a lack of balance and the exaggerated development of one part, which becomes analogous to a parasite.

IV. Education of the Mind

The knowledge of the preceding facts must modify our ideas about the treatment of the illness. No doubt we can more or less easily modify or even suppress this or that fixed idea, but we allow to persist a profoundly dangerous cerebral condition, by which other fixed ideas—indefinitely numerous and sometimes more dangerous than the first—will develop and replace the one we have suppressed. The very power of our suggestions, which seems to us fortunate, is a mark of the profound disorganization of the mind, and the easier the cure seems, the sicker the mind actually is. To continue suppressing fixed ideas one after another as they appear is to condemn oneself to endless labor and to constantly expose the subject to new dangers. At the same time as addressing the local incident that is the fixed idea, we must treat the general state of thought that allows the formation of fixed ideas and that produces suggestibility.

We must not harbor illusions about the rather mediocre power of therapeutics, and we must acknowledge that we know very little about how to treat these nervous exhaustions which are the source of so many accidents. The proposed treatments are countless, and their number does not prove their value. No doubt various tonic treatments can be useful in certain cases, but in the present case, we note that for many years the patient has used and overused all possible treatments

and that, furthermore, the use of medications has increased her hypochondriacal predispositions. Since the effect of medications does not compensate, in our view, for their negative moral influence, we have eliminated them entirely. We have only preserved hydrotherapy, whose beneficial effects we have always appreciated in cases of this kind. But Justine has been receiving showers since childhood without being cured, and we cannot expect from this treatment anything more than very limited help.

Is it easier to treat this mental insufficiency through psychological procedures, and, in particular, can we use here—as before—methods derived from somnambulism and suggestion? It is sometimes the case that the mind, once rid of a fixed idea, spontaneously resumes its activity; but when the mind remains deeply ill after the disappearance of the obsession, we do not believe that suggestions alone can cure it. Some authors think that one can suggest willpower and liberty; in our opinion, this is a mistake in reasoning and observation that we have often pointed out.¹⁷ The patient may seem to obey the suggested will, but he will not be truly free; on the contrary, suggestion develops automatic and subconscious activity and diminishes the last voluntary efforts. The subjects quickly develop a strange and dangerous habit: they are no longer surprised by anything, they accept hallucinations, unconscious movements, the most bizarre upheavals. This is because they have in their magnetizer an absolute confidence and believe that he is the master and responsible for everything that happens in their mind. This indifference, this renunciation of all personal control, is more dangerous, and only contributes more to increasing the fundamental collapse of these patients. In a word, suggestion, like any dangerous medicine—useful in certain cases—can only serve to eliminate and suppress fixed ideas that have become subconscious, over which the subject has no control and which prevent the restoration of mental activity; but beyond its role, it is extremely harmful, for it can only increase the mental disintegration, the principle behind all accidents.

We are therefore obliged to seek a psychological treatment that focuses on the essential points, that increases the power of mental synthesis and the faculties that derive from it—willpower, judgment, attention. Are there methods that achieve this result? Have educators instituted treatments for attention? We regret not having known of them, and we were reduced to using the most banal method to develop a deficient faculty: education and gymnastics.

Cerebral work in the insane raises a sometimes very delicate problem. One is often inclined to believe that these fatigued, overworked minds need rest and are allowed an absolute inactivity which they accept quite willingly. This opinion can often be correct and appropriate in cases of acute neurasthenia, clearly caused by excessive cerebral work, such as preparing for an exam—for example, brain rest as complete as possible will become necessary. But is it so in those chronic neurasthenics who, in reality, have done nothing for years? Is it not the case that prolonged cerebral inertia is just as dangerous as the indefinite immobilization of a limb after a sprain or a fracture? That is what we have thought and what we wanted to verify through experimentation. For many years, we have tried to subject several patients, and in particular Justine, to a treatment method that

¹⁷ *Autom. psych.*, p. 456 and following.

consists of making them work cerebrally in a regular manner, like schoolchildren. Methods of this sort have often been proposed, especially by Legrand du Saulle, who also noted the effects of cerebral work on doubters and obsessives, but this method was, if I'm not mistaken, used differently and understood differently. Legrand du Saulle considered work as a way to distract patients from their obsessions and sought to fill their minds with varied and interesting spectacles. From this stems the recommendation of travel, which often seems to us to be a prejudice: the spectacles are too new, they quickly tire the attention of these people and are no longer consciously perceived. We consider work not as a distraction, but as a kind of gymnastics that increases the power of mental synthesis, the only thing capable of effectively opposing suggestibility and fixed ideas.

Thus we would like to avoid tasks that can be carried out mechanically and without attention; we would like to have patients do only tasks involving judgment and composition. We would also like to grade these tasks according to the duration of attention required and the number of elements that must be synthesized. Perhaps in this way the field of consciousness could be widened, giving the mind the power to maintain several ideas simultaneously, to combine them together, and to oppose them to one another.

There is always, and especially when one places oneself from the medical point of view, an enormous difference between theory and practice. We cannot convey the difficulties we encountered in this singular endeavor of bringing back to school a forty-year-old insane woman. It was difficult to find a task, even more difficult to get her to accept it. Then the work was carried out in exactly the wrong way; it was done automatically without any useful result: Justine read without understanding, could not recite anything but in a somnambulistic manner what she had learned, etc. If the work was done well, it became extremely painful, provoked headaches or even serious accidents, seizures, periods of stupor lasting more than 48 hours, which did not reassure observers of the treatment's effectiveness. It took a true and long-lasting effort to carry out this experiment for years. On one hand, I used all the resources of suggestion, which once again played its role, to compel the patient to do these tasks; on the other, Justine's husband, who was an intelligent and devoted man to this poor woman, showed great patience and great skill in carrying out this singular medical prescription.

Thus we were able at first to obtain a few minutes of conscious attention without incident; we then managed to get the patient to explain a few lines, to do an addition problem, etc. Then the work could be extended to half an hour, day by day without inconvenience. Old memories that seemed erased suddenly reappeared and facilitated the task; after a few days of fruitless effort, Justine would suddenly discover that she knew how to do a multiplication. Small literary compositions could be written, and lessons, a great marvel, could be recited in a waking state. No doubt, from time to time disasters occurred, Justine suddenly became stupid, either from fatigue or because she forgot everything she had just learned for the past three months, and it had to begin all over again. But a new task that we had her undertake produced a remarkable result: Justine began to study music theory and piano and became passionate about music. The natural

attention of which Mr. Ribot rightly spoke joined with commanded attention and education made great progress.

These improvements presented themselves in an interesting way that we have already described in another patient: they were not gradual and continuous, but on the contrary, abrupt and like spasms. The patient would have a few hours of well-being one day, during which she understood everything, felt no more discomfort, and declared herself completely cured. "I find myself again as I was in my childhood; it's been years since I felt like this." Then everything would suddenly fall back again for a more or less long time. These periods were quite analogous to the "clear moments" of Marcelle, and they repeated, lasting for hours, then for entire days. For about a year now, these clear moments have occurred in her about every three weeks and do not disappear except during her menstrual period.

Now that these periods of mental health have lengthened, we can better observe the general result of the education. Justine has acquired some instruction; she can now do the accounting for a small shop and can reasonably decipher easy piano pieces—these are results of which she is very proud, though we will not dwell on them. The truly interesting fact is that most of the symptoms of *aboulia* have been profoundly modified. Physical and intellectual activity is largely restored; the patient continually works in her home, finds it useful, and during the hours devoted to mental work, she tries to solve problems of interest, whereas before she could not understand three lines of a newspaper. Her doubts have disappeared, her memory is normal, and the *anesthesias* can now only very rarely be observed. The visual field still narrows slightly under the influence of attention, but much less than before, and *diplopia* no longer exists. The patient is aware of all these changes and is astonished to realize things she hadn't understood in many years. She feels more capable of affection and, in every respect, happier.

What is more surprising is that her physical health has been affected by these mental changes. Here she is now eating and digesting in the most proper way, and yet, although she eats better than before, she is losing weight: from 197 pounds, she has dropped to 169 in four months, a reduction of 27 pounds. This fact, although explainable, seems to confirm our earlier remark: that her obesity was related to certain pathological nervous phenomena.¹⁸ Her skin is no longer dry, and her complexion is entirely different. One might smile at these observations and find it rather odd that this woman's hair began to grow again when she started writing essays and playing piano. We will simply respond that we are reporting facts and not imagining anything ridiculous. Moreover, one must remember that this woman used to be in a state of continuous delirium, constantly experiencing congestion and motor disturbances related to emotional disturbances, sleeping poorly and eating in a highly irregular way. Today we can force her, through cerebral work, into perfectly correct hygiene, and everything has become calm. Is it not likely that her physical health and general nutrition are responding to these changes?

¹⁸ Esquirol once noted a fact of nearly the same kind: "The termination of delirium attacks," he said, "in an intermittent female patient is marked by a great and rapid weight loss, while the return of the attacks occurs when the patient has regained considerable stoutness." Esquirol, *Des maladies mentales*, 1838, I, 83.

What is more interesting to study, and what was particularly the object of our research, is the phenomenon of suggestibility and fixed ideas. What became of them amid all these changes? The modifications of suggestibility are difficult to assess, because the subject may sense from our way of suggesting whether we wish to be obeyed or not; he may disobey out of obedience. However, we attempted to experiment properly. We never let the subject suspect our research; we occasionally tried suggestions in the waking state and recorded the results without any comment. These experiments are imperfect, we admit, but here are the results nonetheless. Suggestibility, subconscious acts, and disaggregation of the mind have not completely disappeared: somnambulism can still be induced, and for us this indicates the persistence of a pathological sign. At certain times—during menstruation, for example—suggestibility is almost as strong as it was before. But in more favorable periods, suggestibility has greatly diminished, and most suggestions “no longer take.” The subject performs the requested act, but through voluntary obedience, with personal consent, and not by automatic movement. If Justine remains somewhat susceptible to suggestion from us, who naturally have a strong influence over her mind, she now shows resistance when it comes to ideas inspired by other people. She no longer speaks or behaves as if exposed to being suggested to by any word or incident. She senses an idea coming and is able to stop it herself: very often a page of reading or a piece played on the piano has dispelled obsessions which, in the past, would have led to a month of delirium. For the past year, she has had only one serious incident, and even that is almost excusable. A small dog she loved dearly was run over before her eyes; she lost consciousness and reproduced one of her old attacks with fixed idea and delirium; but the attack had no consequences and everything had dissipated the next day. This recovery, even if partial, seems to us to support the opinion that linked suggestibility with the disorders of aboulia and mental disaggregation.

It thus seems that the stern education of the mind has had a beneficial influence: it may not have erased the old fixed ideas, so stubborn, but it has reduced suggestibility and prevented new ideas from developing. The immediate result is satisfactory, but we have already experienced too many disappointments to place too much confidence in it, and we must evaluate and reduce this apparent recovery to its true worth. That is what we will attempt to do by taking an overall look at the evolution of this illness.

V. Evolution of the Illness

Personal and hereditary antecedents

To properly understand a fact, one must try to trace it back to its origin: what is the starting point, the cause of an illness like the one we have just studied? A considerable portion of the symptoms initially depended on the idea of cholera; where did this idea come from? From an emotion, as we have seen, that Justine experienced while going with her mother to bury the dead and seeing two corpses of cholera victims. Should this response be considered an explanation—this entire illness so long, this whole transformation of the mind—does it depend on this simple little accident?

Obviously not, we have seen that fixed ideas do not take root in the mind except through a very particular state of suggestibility. And we know that this suggestibility does not constantly exist in all healthy individuals. No doubt the first fixed idea must greatly disturb the mind and leave in its wake a much greater suggestibility, but already from the beginning there had to be a certain weakness for the first idea to be able to develop. Thus, one must go back beyond this idea of cholera and seek the explanation for the suggestibility itself and for the weakness of synthesis in this mind.

We encounter a second response which also contains a part of the truth and which today must be taken increasingly into account. Justine, one will say, had typhoid fever: infectious diseases, especially this one, are very frequently capable of deeply altering the nervous system and the brain in particular; they provoke convulsions, delirium, and often give rise during convalescence to states of stupor that are designated by the name of mental confusion. These states are precisely characterized by the symptoms of aboulia and disaggregation of the mind carried to the highest degree. The mechanism of these cerebral disturbances is not well known, although one suspects either poisons, toxic substances secreted by the microbes, but the facts are indisputable. Is it not highly likely that infectious diseases play a large role in certain cases of aboulia and mental confusion, especially in the long duration of this mental breakdown, in the appearance of the disaggregation of the mind and of fixed ideas? These remarks are probably very true; by a strange coincidence, all the cases analogous to Justine and Marcelle that we have studied had typhoid fever. People always seek the cause of general paralysis in great traumas: a fall, a blow to the teeth of the lower jaw, like in syphilis in children, or the attack of general paralysis. Moreover, it has been noted, by the observation of many patients, that fixed ideas do not have such a pronounced onset and development except after typhoid fever and are felt even more strongly again after an influenza. The role of these infectious diseases is undeniable.

However, we do not believe that this is yet a complete explanation. First, because infectious diseases do not, in our opinion, have this effect in all individuals, but only in some who present, through their antecedents, special predispositions. Moreover, in the case that concerns us, the obsession with cholera, automatic speech, the splitting of personality had certainly begun years before the typhoid fever. Suggestibility, the disposition toward fixed ideas already existed in Justine's youth, and the study of this earlier period of her life will prove that one must go much further back than the typhoid fever at age nineteen to find whether the origin of the illness is possible there.

Justine was, at the beginning of her life, a prodigy child; very precocious in all things, she astonished by her wisdom and intelligence. Never angry nor tearful, she had an extremely gentle and amiable character, she was even said to be too reasonable, and it is claimed that at five years old she spoke seriously like a little woman. We readily accept these accounts, for we ourselves saw in the hospital absolutely astonishing prodigy children. One little girl especially struck us: at nine years old, she ran a household and spoke seriously of the worries caused to her mother by the conduct of her elder brother. At the same time began the anorexias

and deliria that foreshadowed the end of this intelligence that was too precocious. It was the same for Justine: around six or seven years old a very important phenomenon appeared which, to our great regret, we cannot confirm with absolute certainty. The family recalls recurring cerebral accidents that resembled meningitis, illnesses beginning with a pallor of the face, then violent headaches provoking sharp cries, convulsions from time to time, deviation of the eyes, vomiting, states of stupor. But what is embarrassing is that these accidents lasted only a short time, two days at most, and recurred several times every year, without all being accompanied by an elevation in temperature. Justine claims today to remember one of these fevers. This information is very vague. Is it a real meningitis, which could prepare the alienation, or rather was it the pseudo-meningitis of the hysteric, prepared by preceding symptoms that were not noticed? We cannot determine that today.

These attacks repeated very frequently over several years, and at the same time, a total upheaval of character was noted. The child remained very intelligent and learned everything that was expected of her, but she was stubborn, emotionally sensitive, and extremely angry. Certain feelings were so exaggerated in her that they already resembled fixed ideas and provoked formidable episodes; I will cite only two examples. Justine had a horror of crawling animals, worms, slugs, and had an excessive passion for other animals, particularly for cats. To cure her of her terrors, the family doctor recommended at least a strange remedy: on his advice, during a walk, a large slug was secretly placed on the child's neck, who was then nine years old. The effect was marvelous: Justine fell to the ground unconscious and completely contracted. She came to with difficulty and remained for several days absolutely obsessed by the memory of the slug; she rubbed her neck as if she still felt the contact and followed with her eyes the hands of those around her to see if they were hiding anything. Eight days after the incident, she had a severe case of jaundice, which here seems clearly related to the emotion.

The other feeling, her passion for cats, gave rise to the second serious episode. Justine had a little cat that was accidentally injured: a hysterical attack followed, along with bouts of very curious urticaria. A few days later, despite her cries and tears, the poor animal was euthanized, being infirm. For Justine, this was the occasion for an incredible upheaval. Not only did the convulsive attacks and, subsequently, jaundice return, but her whole constitution changed—she became obese, to the point of being barely able to move. At ten years old, she weighed 119 pounds. This is again a phenomenon that is poorly understood and difficult to interpret from such distant accounts. On different parts of her body, mainly on the protruding areas—shoulders, breasts, abdomen, calves—small bumps appeared symmetrically on both sides, then bluish patches, and her skin became hardened; a small sore gradually formed without pain and did not heal except very slowly. Menstruation appeared, with great difficulty, around the age of fourteen, which brought about a change: the obesity and trophic disorders disappeared.

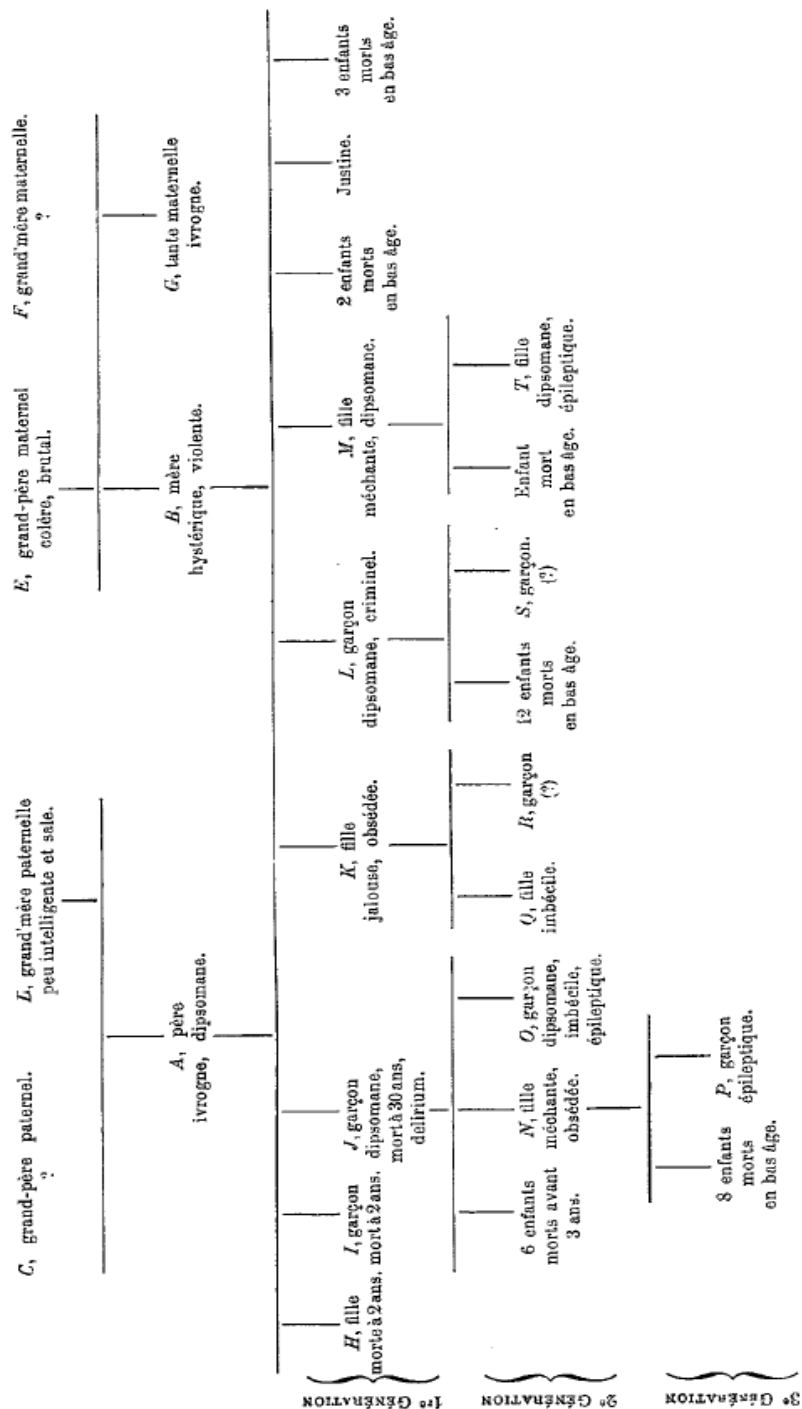
But already at that moment, no doubt due to her mother's occupation as a nurse, Justine was obsessed with the fear of illness and death. Migraines, and even deliria that seemed inexplicable, were provoked by this fixed idea that the young girl still refused to admit. The sight of the two cholera victims delivered the final

blow to this already severely shaken intelligence and defined the nature of the illness that was to become permanently established.

According to this very brief account, is it not clear that the mental illness dates back to early childhood, that it depends neither on the typhoid fever nor on any particular emotion, but rather on a general predisposition of the brain? To find the origin of this obvious predisposition, one must go further back than the individual life of the patient and examine the family to which she belongs.

The difficulty of gathering information about the patient's family is very great, and it took a lot of effort and patience to compile the accompanying chart, which is still incomplete. The information on the grandparents is entirely insufficient, and two individuals, R and S, have disappeared or at least are unknown to the people I interviewed. Despite its gaps, this chart seems quite instructive. Justine's father, A, was an intelligent and hard-working laborer who managed to set up a small business and to live with a certain level of comfort. Unfortunately, he had been a drunkard since his youth, and as he aged, this vice took on increasingly obvious signs of illness. He would remain drunk for weeks and even months at a time, then, after an emotional episode, would suddenly stop and remain sober for several full days. His wife does not interest us here; she died of smallpox. But as we shall see, she already showed signs of the disposition, just as we clearly see them in the children. It would be very interesting to know exactly what Justine's parents thought of their children's disorders. One of the daughters died at age 13 in a convulsive crisis. Another daughter, E, was the wife of grandfather C, but we don't know much about her. However, E was a very intelligent woman and died a sordid death. Up to now, the mental illness in A and his wife seems to have existed independently of marriage. Unfortunately, A married a woman B who already showed some neurotic tendencies; she had violent fits of rage, and her daughter E also had this same character—she was, it seems, subject to violent and prolonged fits of anger. It is in the paternal lineage that we find, in a slightly more complicated form, the violent rages, which led to loss of consciousness and ended in convulsions; paternal vice clearly existed, and it was perpetuated in the family through the brutality of a hysterical and intemperate woman. The union of two nervous tendencies—one clearly showing the disposition, the other prone to hysterical and aggressive fits—worsened the predisposition and led to the ruin and death of the family.

FAMILLE L.



Let us indeed examine the descendants of these two individuals. They are, at first glance, very numerous, for in half a century 46 people descended from this first couple. One could already note the great fecundity of the women in this family, some of whom had 10 and 12 children; certain authors already see in this high fecundity a sign of degeneracy. But fecundity depends on too many circumstances for us to insist on this trait—other facts are far more important.

We are first struck by the large number of children in this family who died at a young age, that is, before the age of three. 34 children out of 46—that is to say 74 out of 100 (the average being well below 20 out of 100)—is that not an enormous proportion, all the more inexplicable since we do not see in the family, except for this misery, any major transmissible diseases, no tuberculosis, nor syphilis? How did these children die? It is difficult to know, and the symptoms may have been reported in a vague way. Obviously, among these 34 deaths, we must count various infections, diarrhea, meningitis. But we believe, however, that infection plays only a secondary role, and we cannot find ridiculous the vulgar expression that Justine used when speaking of her little nephews: “They are fully alive, they stay that way for a month or two, all plump and rosy... then they fade away like candles.” What strikes us most is this extreme mortality as a hereditary fact, a fact which only appears little by little as an accident, but with increasing frequency in each successive generation. In the descendants of A and B (1st generation of our chart) we count 7 children out of 12 dead in the first generation, that is, 58 out of 100; in the following generation 19 out of 25, that is, 76 out of 100; in the last generation 8 out of 9, or 88 out of 100. Truly, if a fourth generation comes into the world—which seems quite doubtful—we can predict it will not live long.

Let us now consider the descendants of A and B who survived. In the first generation, we see that all the living children are affected, to varying degrees, by the same illness as Justine; they all have disaggregated minds and are tormented by impulses and obsessions. The content of the obsession alone differs: in K, it is fixed ideas of jealousy, of blind and cruel anger; in J, it is an impulse to drink. These latter impulses are now absolutely pathological: the unfortunate man would lose awareness at the onset of the attack, drink whatever he encountered, sleep under bridges and in streams, and awaken after eight days, dazed and without memory. He had his “nine-day binges,” when he drank, according to the expression of his sisters; he died of delirium. Finally, L and M combine the two fundamental vices of the race that have become the delusions of the descendants: they are dipsomaniacs and also have their “nine-day binges,” but in addition they have impulses toward violence and even toward murder.

Let us move on to the second generation; we see the same traits of the family—obsessions and violence in N, dipsomania in O and T. But now we also see new symptoms appear: here are the epileptics and the imbeciles, O, Q, T, and in the last generation, there remains only one unfortunate epileptic boy who will hardly redeem the fallen family. The history of this family is absolutely identical to those that served to establish Morel’s theory of the definitive degenerations of a race. Fortunately, evolution is not always so fatal. It is quite true that families have, like individuals, certain illnesses, some of which are temporary or only

affect one or two generations, while others are serious and, after a few generations, lead to the death of the line. In the case we are studying, the two illnesses that were mild in the two original families came together and formed a deadly illness.

This brief description has not taken us too far from our subject, for it seems to us that Justine becomes much more intelligible when she is placed back in her milieu. One can no longer think of attributing her illness to some accidental cause, emotion, or typhoid fever, when we see all her relatives who did not have the same incidents exhibiting the same symptoms. It is probable that the fundamental psychological lesion is the same in all the members of this family; under the influence of heredity and alcoholic intoxication, the higher functions of the brain—the current synthesis functions—diminish and disappear. Justine's cerebral state is one step along this path leading to the imbeciles who end the family, and it is not wrong to say that the origin of such a disease is mental degeneration.

This degeneration has taken on here a special form that can be found in other circumstances and that we have called the disaggregation of the mind. In short, it is a particular variety of psychological disaggregation. The poorly synthesized psychological phenomena tend to arrange themselves into two groups clearly distinct from one another. We have observed anesthetics, amnesias, subconscious acts, somnambulisms, etc. Without a doubt, the separation is not always absolutely as clear as in typical cases, but it is sufficiently marked. This mental disaggregation here takes the form of hysteria. In a word, we are dealing with a mental disaggregation of hereditary origin in a hysterical form.

We can also, based on this new information, better appreciate the effects of our treatment. We are far from considering these hereditary illnesses as incurable and hopeless. The diseases of the race can be healed just like the diseases of the individual, and in other genealogical charts, we see the family recover after having been seriously affected for one or two generations. But we know at least that the illness goes beyond the individual, that it has a long-term evolution and cannot be transformed by a few remedies applied momentarily to a single person. It is unlikely that a patient like Justine could be completely cured of such an old and deep-seated illness. After describing this person's certain and undeniable progress, we must, in order to properly assess the methods used, acknowledge the gaps and the lesions that remain.

The true sign of a cure from illness is the departure of the doctor, whom one sends away with pleasure; unfortunately, this sign does not exist among the patients we are dealing with—they are always incapable of sending their doctor away. All the progress we have described in Justine's mental state has only been obtained and maintained through the continual influence we exert over her. This influence exerted by the doctor on patients seems to us to be of major importance in these disturbances of the mind; it constitutes a pathognomonic feature of certain mental illnesses. Without studying this phenomenon in general here, let us merely recall how it is that Justine can come to appear reasonable.

When Justine comes to see us, she is often in a pitiful state; she has just had more or less severe attacks, she is obsessed by old fixed ideas that have

reappeared or by new fixed ideas that have taken hold. She has given up her usual work in recent days, as she was no longer capable of such effort; she remains inactive and cannot understand anything; her memory is gone, her sensitivity diminished, her visual perception altered in various ways. Finally, Justine feels *isolated*, without support, and gives herself over to despair.

All these disturbances depend in part on a very serious fact that cannot be emphasized enough: the need for somnambulism. On the one hand, somnambulism is analogous to the attacks and replaces them; it seems that the second existence must necessarily unfold in some form, and when it is forbidden one kind of manifestation, it tends to produce another. On the other hand, these subjects are prone to habit and automatism to the point that they feel an intense need to be in a state of sleep. This need—which must never be allowed to arise without medical acknowledgment of its necessity—seems to us as dangerous as the need for morphine, for it partly causes the disorders we observe in the patient upon her arrival. But there is, let us believe, still a different kind of need that manifests even in subjects of this kind who are not put to sleep: it is the need to confess, to be scolded, to be directed. This need is of astonishing force; it appears in its most intense form in all hysterics, in neurasthenics, in the anxious, the obsessed, etc.—in all individuals whose personal will is very weakened. Justine not only wants to be put to sleep, she wants to be suggested to, to be ruled by an external authority that can regulate all the psychological phenomena she is incapable of directing herself.

After the session used for all the investigations and operations that were described, some patients are immediately restored. It is not so with Justine: the struggle against fixed ideas, the more or less aborted attacks in their development which disturbed the somnambulism, have exhausted her, and despite all sorts of precautions she remains very fatigued after the session. This discomfort lasts for half a day or even a whole day before a state of well-being begins. Justine no longer has fixed ideas, she feels energetic, capable of will and attention; she works regularly, studies with focus, and feels full of confidence: “It seems to me that someone has given me a guardian—I am no longer alone.”

This feeling of “support” corresponds to very clear psychological facts that we cannot analyze here. The idea of a “director of consciousness” persists in the minds of these patients without their knowledge. I tried to reproduce an experiment of the English psychologists, “crystal-gazing,” with a patient, Marguerite, during this period of confidence which followed her somnambulisms. It is known that in this experiment, subjects gaze fixedly into a mirror or a crystal ball and have visual hallucinations connected with their forgotten dreams, their subconscious phenomena. When Marguerite looked into this crystal ball during the days following the somnambulism, she saw my portrait; by contrast, if she looked in the same way a month later, during the days of “isolation” which preceded the somnambulism, she saw only images of her dreams. This hallucination did not depend on her conscious thoughts, because in the second period, she wanted to see me and thought of me more than in the first. This latent and more curious influence still appears in Justine and manifests most spontaneously through hallucinations. Justine, while walking in the streets, finds

herself in front of the door of a hospital and, following her bad habit, thinks of death, is frightened, and wants to make a great detour to avoid passing in front of the door. But here is an unforeseen obstacle: she suddenly sees me in the middle of the street: "It was indeed you, also dressed as you are now, you were blocking my path; you made me go through the hospital door, and when the door was crossed, you started laughing and I don't know what you said to me." In other circumstances, these are auditory hallucinations: she hears me giving her advice, and this so vividly that she turns around and asks if I am there. She hears me urging her to undertake extraordinary things with my colleagues; she asks me for advice, and it seems that I answer her well. What is most curious is that these pieces of advice are not merely the repetition of those I gave her during the somnambulism. These are new questions that I had never spoken to her about; fortunately, she attributes to me only very wise words. Such direction, even if it results in apparent health, is still a singularly pathological fact.

No doubt Justine, through intellectual work, manages to increase her power of attention, to synthesize her phenomena a little better; but this result is obtained only at the cost of enormous and continuous effort. She is constantly, if we may make a similar comparison, in the state we ourselves are in when we have to prepare for a competitive exam or write a complicated book. She needs, for everyday life and banal perceptions, as much effort as other people need to produce an original and difficult work. So it is quite natural that she becomes tired and discouraged: "I know well that if I stop working, I will go mad; but it's so tiring and I can't take it anymore!" The automatic phenomena invade her once again; the need for direction, for encouragement, is once again just as strong, and Justine must return to her doctor.

This continual need for moral direction can take many different forms: it may be the somnambulistic passion of hysterics, the desire for affirmation from outside oneself in doubters, or simply the need for affection, the fear of solitude, etc. Its study is very interesting, for it allows us to penetrate almost experimentally into the analysis of moral feelings, but it nonetheless constitutes one of the great difficulties of mental therapeutics. In certain cases, one can say that it makes any such therapy absolutely impossible. Many patients we have known can theoretically be cured, but one must devote oneself to them and lift them up continuously at least once a day. Such sessions are tiring, they are not always interesting, and above all, they are extremely long. Treatments of this kind are practically impossible.

After having tried to take direction of the patient's mind, we arrive at a new problem: reducing this direction to the strictly necessary—namely, spacing out the sessions devoted to the patient. It is very rare for this latter problem to be resolved in a complete way, and we count only a small number of patients whom we have been able to abandon more or less completely to themselves. In a few cases, and with Justine in particular, the problem is partially resolved when we are able to space out the patient's visits a little.

At the beginning of my studies, it was necessary to see Justine frequently several times a week, then one session per week was sufficient for a long time. We then managed, without difficulty, to give the patient only one consultation per

month, which she tolerated quite well. But we could not go further: recently, after trying to space sessions six weeks apart, we saw her bad symptoms reappear. It must be acknowledged, however, that visits to Justine are not wasted time. Some patients with organic disorders or disabilities need to see a doctor every month! But it is no less true that this person, even if functionally restored, even if no longer completely ill, remains infirm. Our excellent teacher Mr. Jules Falret once told an anecdote which was not well understood in the past and now seems to clarify some of our studies. The alienist of Rouen, Morel, had undertaken the treatment of a very agitated woman by the processes of magnetic influence and moral authority. He succeeded marvelously and managed to have the patient leave the asylum; she saw him very frequently and was not ill as long as these repeated visits allowed her to witness the effects of his care. Morel left for a month, and upon his return, the patient, now delirious, had to be locked up again in the asylum—this time definitively. We hope that such an accident will not happen too soon to our patients, but we see clearly that if, for one reason or another, they were abandoned, they would very quickly relapse. This limitation of therapeutic action—this powerlessness in definitively transforming the thinking of the subjects—serves to confirm our studies on the origin of the illness. The hereditary lesion is too deep; it forms across several generations; it can only be repaired very slowly through new generations. In the course of individual life, it can be more or less alleviated, but not cured.

It is pointless to insist on these general remarks, which would be poorly justified by the study of a single patient; we have only wished to make one observation. It has allowed us to confirm earlier remarks on hysterical phenomena, and in particular on phenomena of aboulia. It has shown us some new details, not without significance, on fixed ideas and their treatment. Perhaps it is not without interest for psychology either: the nature of certain ideas, their systematization, their disaggregation, their reduction to partial and incomplete phenomena seem to apply to the interpretation of the healthy mind just as much as to that of the diseased mind. Pedagogy and morality cannot ignore the efforts required to maintain intellectual work, the progress of attention, the need for sympathy and guidance. It is by gathering such observations that one will gradually come to understand both the sick mind and the mind that seems healthy.

Dr. Pierre Janet